



Wisconsin Autism Transition
Demonstration Project

WAuTD Project Kickoff Meeting

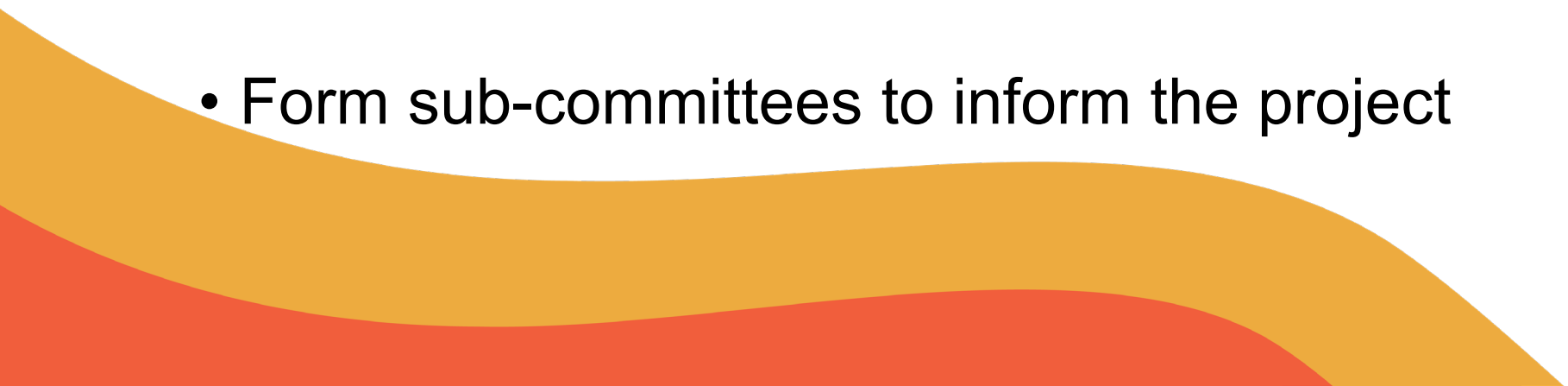
Dec 9, 2025

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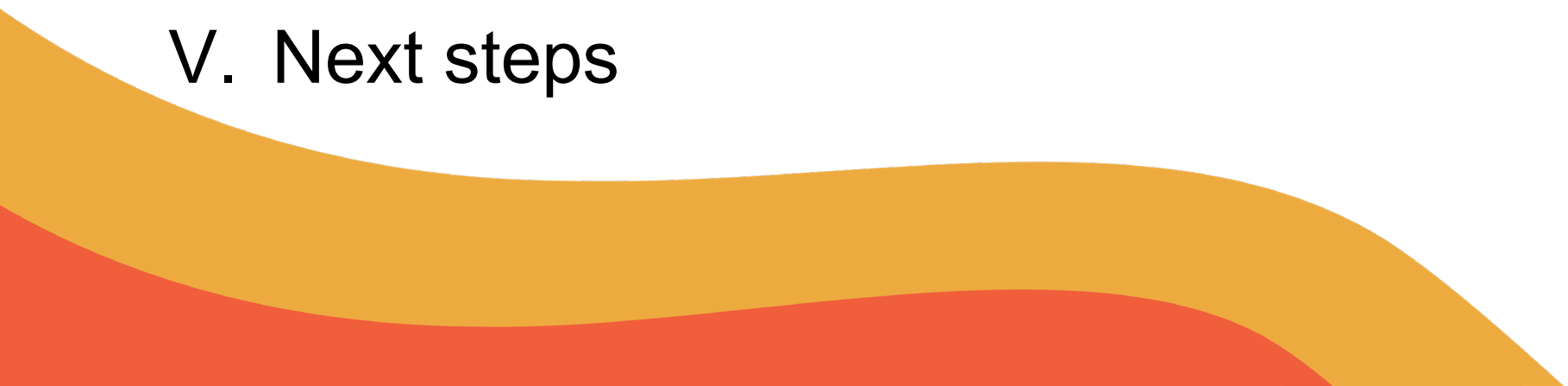


WAISMAN CENTER
University Center for Excellence in Developmental Disabilities

Meeting objectives

- Introduce the WAuTD Project and its plans
 - Share what we learned in the past year about the status of transition from child to adult services
 - Gather your feedback about strengths, weaknesses, and opportunities for transition services/support in Wisconsin (but especially in Rock County)
 - Form sub-committees to inform the project
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Meeting agenda

- I. Welcome and introductions
 - II. WAuTD project introduction
 - III. Sharing what we learned
 - IV. Getting your feedback
 - V. Next steps
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Key project staff



Gail Chodron - PI



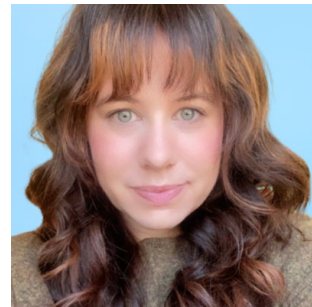
Leann DaWalt – Co-PI



Lynn Hrabik – Co-PI



Tim Markle – Training &
Transition Coordinator



Kaitlin McNamara –
Contractor / SME



Julie Schears – Project
Coordinator

Project history and purpose

Autism Collaboration, Accountability, Research, Education, and Support (CARES) Act of 2014

Federal legislation aims to support:

- ❖ Interagency coordination
- ❖ Surveillance and Research
- ❖ Professional training and public education
- ❖ State systems for early identification, diagnosis, and intervention



➤ Learn the Signs. Act Early (LTSAE) Monitoring



Act Early Ambassadors

State Systems for Early Identification, Diagnosis, Intervention

Act Early State Team (2007-23)

Autism state demonstration grant (2008-10)

- “Connections Initiative”
- Community of Practice on Autism Spectrum Disorders (*still active today*)

Act Early State Systems Grants (2012, 2014-15)

- Learn the Signs. Act Early. materials in public health programs

Autism Innovations in Care Integration grant (2016-19; 2019-24)

- Improving access for medically underserved families
- Family navigation
- Partnering with primary care providers and community partners

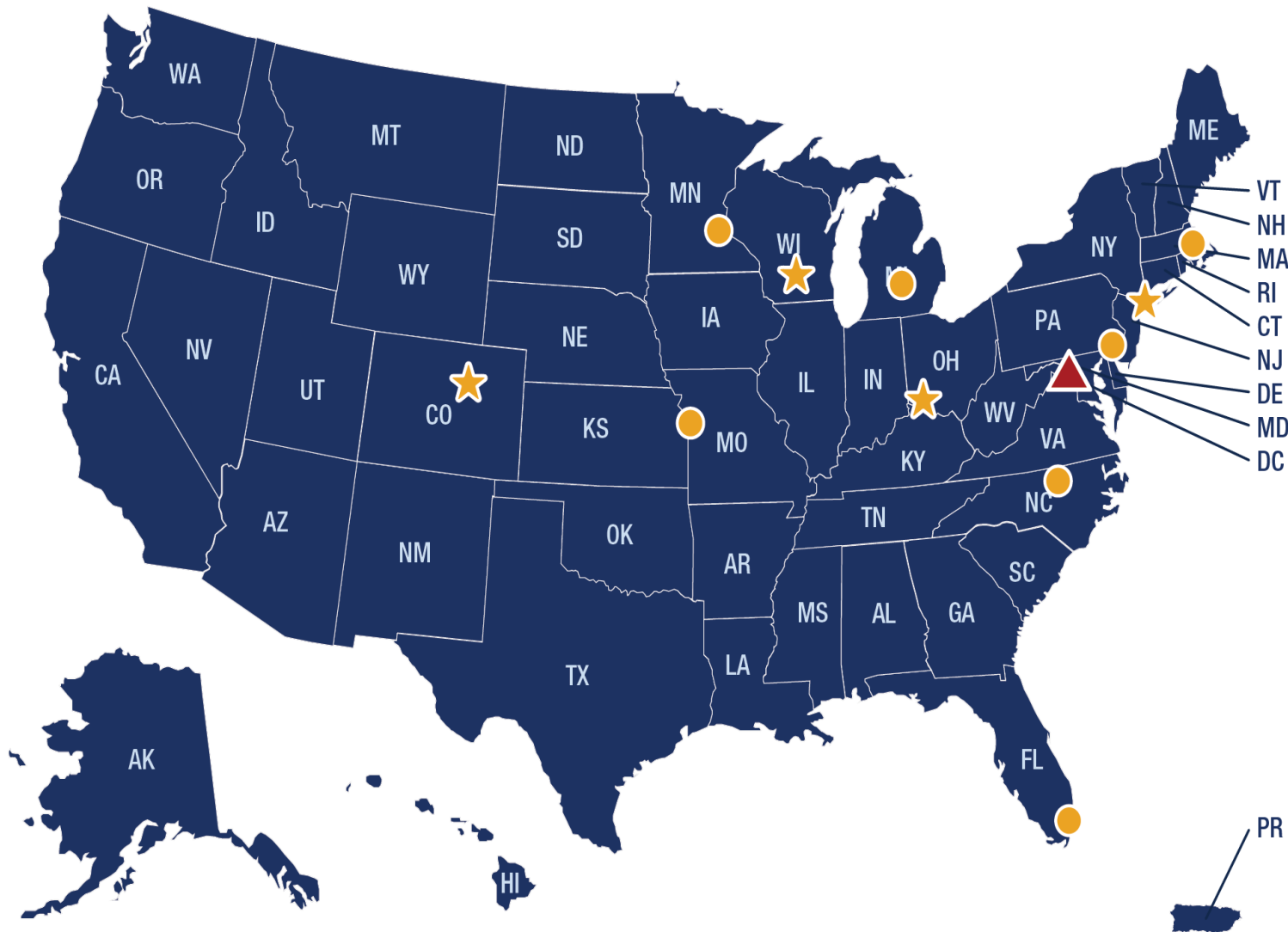
***New focus: Autism Transition Demonstration Project (2024-29)**

Transition to Adulthood Systems Change Projects

- Youth Health Transition Initiative (2013 – 2025)
 - Wisconsin Integrated Transition Planning Project (2020 – 2024)
 - Wisconsin Transition Autism Demonstration Project (2024 – 2029)
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- Listening to and co-designing with youth and families
- Start transition planning early with high expectations
- Break down system silos





Transition for Youth with Autism and/or Epilepsy Program Awardees

★ Autism Demonstration Project Awardee

- Cincinnati Children's Hospital Medical Center
- Long Island Jewish Medical Center
- University of Colorado
- University of Wisconsin - Madison

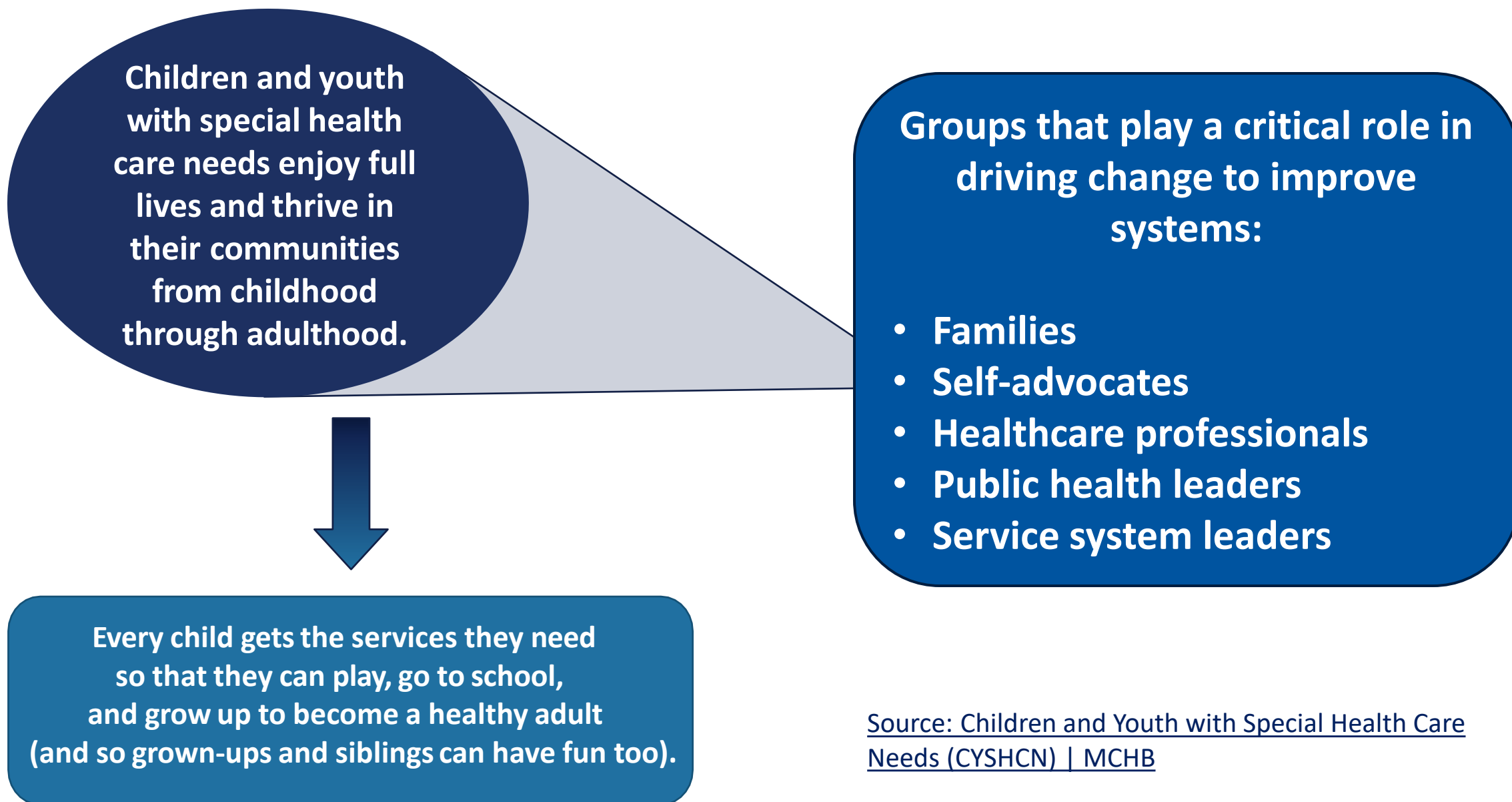
● Epilepsy Demonstration Project Awardee

- Boston Medical Center
- Children's Hospital of Philadelphia
- Children's Mercy Hospital
- Epilepsy Alliance Florida
- Michigan Department of Health and Human Services
- University of Minnesota
- University of North Carolina at Chapel Hill

▲ National Coordinating Center on Transition

- Association of Maternal and Child Health Programs

Blueprint for Change: Guiding Principals for Transition Program



Source: Children and Youth with Special Health Care Needs (CYSHCN) | MCHB



Demonstration Projects

Sept 1, 2024 to Aug 31, 2029

Implement and evaluate innovative, sustainable, and scalable strategies that support and improve outcomes for autistic youth and their families/caregivers transitioning from child to adult serving systems.

- Create framework for successful transition
- Family navigation to support self-efficacy
- Build partnerships across systems
- Life course approach

Child and Adult Serving Systems



- The goal is to improve outcomes including quality of life and well-being for autistic youth and their families/caregivers transitioning from child to adult systems.
- These systems include but are not limited to post- secondary education, inclusive post-secondary education, employment, community, independent/daily living, and healthcare.

Target Population

Youth with autism who have complex health and social needs and require a higher level of family support and coordination

Between the ages of 13 and 26

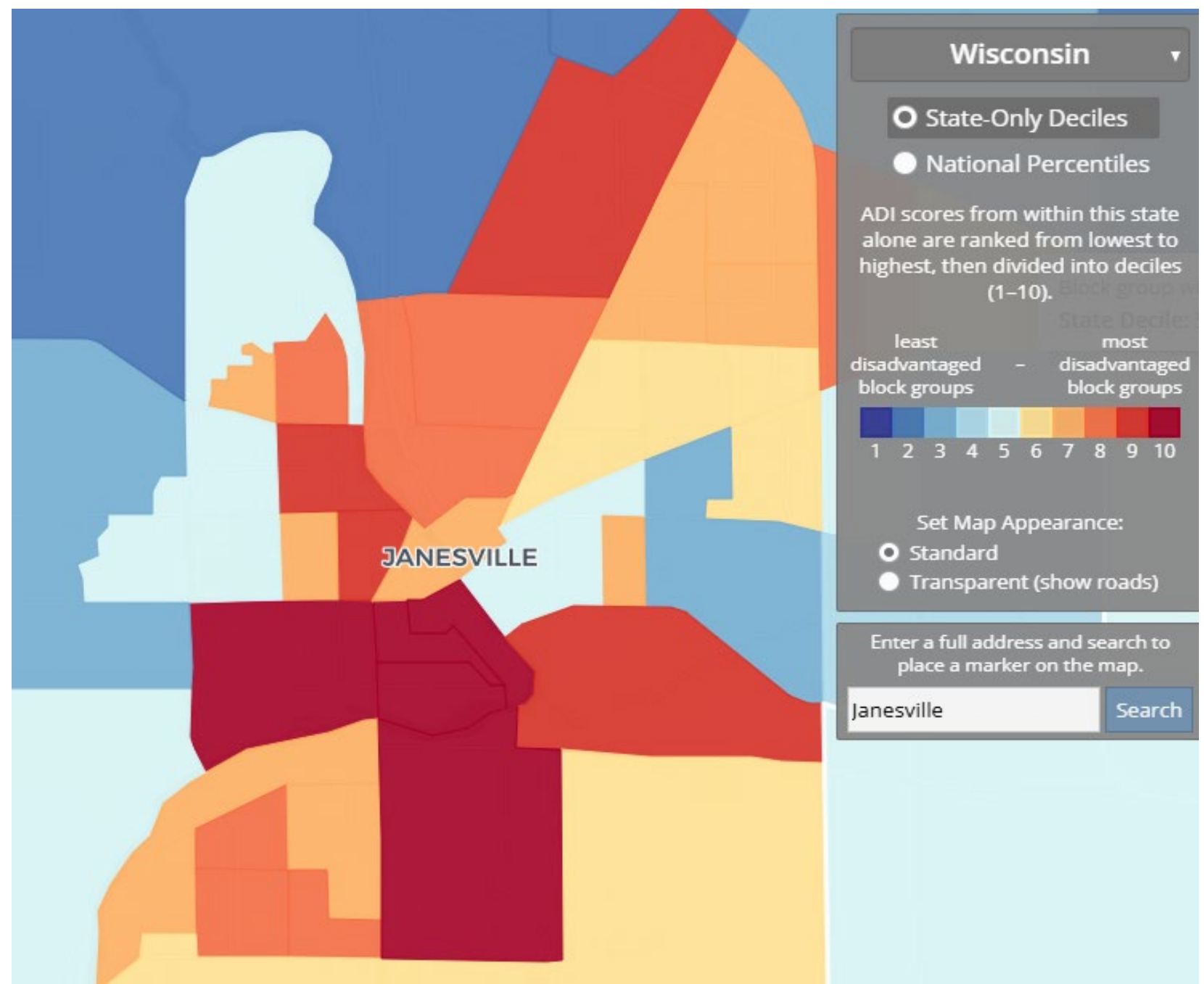
- Co-occurring conditions
- Intellectual disabilities

Experience challenges in

- Social cognition
- Communication
- Interpersonal skills and/or behaviors

Require a higher level of family support and coordination.

Catchment Area



Available online at
<https://www.neighborhoodatlas.medicine.wisc.edu/>).



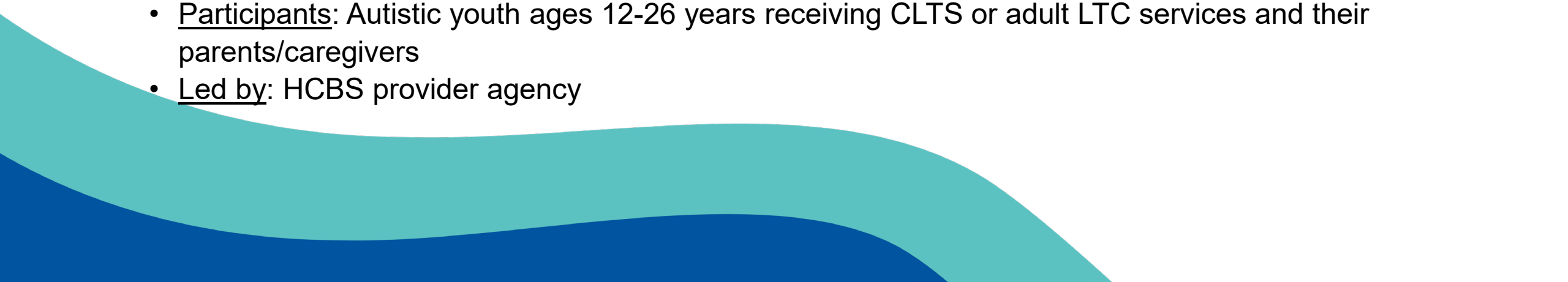
Goal is to NOT duplicate or replace what is happening already but to determine how/if it is working for autistic youth who have complex health and social needs and require a higher level of family support and coordination.

Pilot strategies that help youth & families navigate systems

1. Integrated Transition Consultations

- Description: Series of 2-4 individualized consultations with a multidisciplinary team to discuss youth and family goals and share resources available to autistic transition-age youth.
- Participants: Autistic youth ages 12-26 years receiving CLTS or adult LTC services and their parents/caregivers
- Led by: Representatives from education, employment, health and other systems with a peer

2. Professional-led Cohort Groups

- Description: Length TBD; Sessions to learn new life skills with an emphasis on accessing the community
 - Participants: Autistic youth ages 12-26 years receiving CLTS or adult LTC services and their parents/caregivers
 - Led by: HCBS provider agency
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Pilot strategies that help youth & families navigate systems

3. Peer-led Cohort Groups

a. Parent/Caregiver-led Peer Cohort Groups

- Description: 6 weekly sessions with a small cohort of parents/caregivers led by a parent of an autistic adult. These connections are designed to help families overcome isolation, share common experiences, build resiliency, and learn from one another.
- Participants: Parents/Caregivers of autistic youth ages 12-26 years receiving CLTS or adult LTC services.
- Led by: HCBS provider agency and/or peer advocacy agency

a. Autistic Youth-led Peer Cohort Groups

- Description: 6 weekly sessions with small cohort of similar age youth led by an autistic peer mentor. These connections are designed to provide supports through the benefit of shared experiences, and to build bridges to people and resources within their community.
- Participants: Autistic youth ages 12-26 years receiving CLTS or adult LTC services
- Led by: HCBS provider agency and/or peer advocacy agency

Pilot strategies that help youth & families navigate systems

4. Transitioning Together / Working Together

- Description: An 8-session multi-family group psychoeducation program that provides education and support to parents, fosters social interaction and learning for adolescents, and emphasizes positivity and problem solving. The curriculum is adaptable to different settings, including clinical settings and school settings. After two individualized family sessions, youth and parents/caregivers meet separately. Sessions would be run for different age groups.
- Participants: Autistic youth ages 12-26 years receiving CLTS or adult LTC services and their parents/caregivers
- Led by: TBD – looking for interested agencies

Measuring Successful Transition & Self-efficacy

Collect baseline for youth in early 2026 and repeat each year. Some examples ...

- This youth can get to places they need to go, like to work or doctor's appointments. They do this with support from family members, if needed. *(For example, they may get there by driving, getting a ride, taking public transportation, riding my bike, walking, or some other way)*
- This youth gets to make choices in their life. *(For example, they can decide or have input into how they spend their money, what I do with their free time, where they live, and who they live with.)*
- This youth has a community they belong to. *(For example, this youth belongs at the place they work, with their classmates, or in their online community.)*
- The people who are supposed to help this youth treat them with dignity and respect. *(For example, their doctors and other professionals listen to what they have to say.)*
- This youth is able to get the mental health care they need. They do this with support from family members, if needed. *(For example, they are able to find a counselor or a therapist if they need one.)*
- This youth is happy with where they live.

What We Learned in the Planning Year

- Data is limited for this specific group
 - Discussions at state and federal level and proposed policy changes are creating uncertainty
 - Lots of great work, interest and passion
 - High needs but also opportunities
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Education (including K-12, 18-21 programs, career and technical education, post-secondary and inclusive post-secondary programs)

Strengths:

- DPI and other partners have created a lot of programs, training and resources related to transition.
- The County Community on Transition (CCoT) Team maps resources in education, employment and independent living to assist in understanding the service systems for all transition partners. They foster partnerships and improved communication between staff in different systems.

Weaknesses:

- Too few autistic students are enrolled in post-secondary education
- There are no inclusive post-secondary programs within the catchment area. However, there is a program in SE WI at UW-Whitewater, and others in the state. Cost has been mentioned as a key barrier for some families.

Opportunities:

- Replicate UW-Whitewater's Center for Innovative Transition, Education and Employment (CITEE) on a middle school college day event?
- Partnership with local CCOT?

Employment [including paid and volunteer opportunities, internships, etc.]

Strengths:

- WI transition law directs schools to start employment planning with youth with disabilities at age 14. Youth and families can request that their IEP include job exploration, internships, and work at school or in the community.
- WI DVR services can start at least two years before students exit school and DVR counselors can attend IEP meetings to help explore interests and goals for employment. DVR can support youth and young adults to employment service providers, job sites, internships, and courses to support future employment.
- Work Incentives Benefits Counseling is available if there are concerns about the impact of income on benefits (<https://eri-wi.org/services/wipa/> Some youth are eligible for free benefits counseling, and for others it can be added to service plans with Family Care or IRIS, or it can be part of their DVR services.
- Job Search has an active program within the catchment area

Employment [including paid and volunteer opportunities, internships, etc.]

Weaknesses:

- Youth/young adults with disabilities are not employed at the same rates as their neurotypical peers. Stakeholders report that these youth may be encouraged to work in settings that will accept them rather than explore areas of interest to them.
- DVR vendors have high caseloads and low funding, and stakeholders report that youth/young adults aren't being supported early or often enough to succeed.

Opportunities:

- There is more support for including self-employment exploration as part of the Post-Secondary Transition Plan (PTP) within schools, and including job shadowing and work experiences with self-employed community members through DVR. Some autistic youth may find that self-employment is a better fit than other employment options.
- Many HCBS providers support employment and seeking innovative solutions

Community living (including housing, transportation, social opportunities, safety and rights)

Strengths:

- There are a variety of opportunities for youth/young adults to connect with others including the Boys and Girls Club, Special Olympics, Islands of Brilliance, Autism Society of South Central WI and Space Autastic, among others
- There is accessible public transportation in most urban areas.

Weaknesses:

- Partners report limited housing options for youth/young adults with disabilities.
- Housing options may not be accessible – money, location, supports, etc.
- Transportation access limited in non-urban areas

Opportunities:

- Many transition to adulthood partners who are interested in expanding housing and transportation options

Independent/daily living (including waiver programs and services)

Strengths:

- The CLTS Program has eliminated the waiting list over the past 8 years. On average it takes 44 days between a referral to the program and enrollment with the creation of an Individual Service Plan; this is much lower than the benchmark of 90 days.
- The CLTS Family Manual was updated in 2025. This version was reviewed by multiple families, translated in Hmong and Spanish and a hard copy was mailed to all enrolled families. Section 12 is on “Transition Planning” which recommends transition planning to begin early but no later than the youth’s 14th birthday.
- WI adults with disabilities who qualify for long-term supports can choose Family Care, a managed care program, or a self-directed program called Include, Respect, I Self-Direct (IRIS). Some counties (including our catchment area) also have a third option called Family Care Partnership, which adds health care services to the individual’s long-term support, managed care services. These programs are all funded by Medicaid.

Independent/daily living (including waiver programs and services)

Weaknesses:

- There continues to be a high turnover rate in CLTS Support and Service Coordination and staff. Remaining staff have high caseloads and families report concerns getting timely information and support.
- The Caregiver Workforce Shortage and a limited number of vendors/workers in some areas of the state (especially rural areas) limits access and choice.

Opportunities:

- The CLTS Waiver renewal process is in motion. The new waiver will be in effect from 2027-2031. Individuals provided comments from mid-September to mid-October 2025 through email, an online survey or focus groups.
- In 2024, the CLTS Program began a Transition Resource Services Overview Project. The goal of the project is to provide more clear information on the services that participants could receive in the adult system that are relative to services in CLTS, and to encourage staff and families to begin talking about the transition out of the CLTS Program no later than age 14. This is a quality improvement project based on family and Advisory Committee feedback.

Healthcare (including physical, mental and dental health)

Strengths:

- There are a variety of systems/clinics within the catchment area for youth/young adults to seek health care, including a primary health and dental care clinic that offers free or low-cost services.
- There are a number of ways that families can learn about and get support in navigating the transition to adult health care.

Weaknesses:

- While evidence-based practices exist for supporting youth to transition from child to adult healthcare systems, there is limited time, tools and payment structures to fully implement them in health systems.
- There is access to behavioral / mental health treatment and autism therapies but it is difficult for youth/young adults with autism to receive care from providers who understand both.
- ABA therapy is readily available for children age 5 and younger, but is difficult for older youth to access this therapy or other autism therapies due to staffing issues for afterschool hours, and additional Medicaid authorization paperwork.

Opportunities:

- ECHO and other training provider models
- Electronic Health Record software embedding more transition tools

Questions...



We Want to Hear From You

A blue starburst graphic with a white border, containing the text "You pick 2 groups!".

You pick
2
groups!

Breakout rooms for two 20-minute conversations

1. Health & wellness (physical, mental, dental health) – Tim Markle
2. Education & employment – Lynn Hrabik
3. Integrated community living – Kaitlin McNamara

For this discussion, we'd like your ideas about:

[1: health & wellness, 2: education & employment, 3: integrated community living]
for autistic people ages 13 to 26 with more challenging health or social needs who need more support than other young people.

- What do you feel is going well?
- What isn't going well?
- What are things we can do to make it better?

Next steps

- Host project meetings 4xs per year
- Share Landscape Analysis documents
- Form sub-committees that will meet at least once between meetings
- Email a recap of this meeting including way for you to officially sign up for sub-committees
- Gather meeting feedback



THANK YOU!